

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 8 2 3 0 1 2	
1. DECEASED NAME (TYPE OR PRINT) George Richard Benton				2a. DATE OF DEATH MONTH DAY YEAR November 7, 1982			2b. HOURS 5 A.M. _M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 5, 1897			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 84 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's Co. MD.				
10. CITY OR TOWN OF DEATH Queenstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt#1 Box#2 Margaret Smith's home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Q.A. Co.		13c. CITY OR TOWN Queenstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rt#1 Box#2			
14. FATHER'S NAME FIRST George		MIDDLE R.		LAST Benton		15. MOTHER'S MAIDEN NAME FIRST Alice		MIDDLE LAST Hopkins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219-22-4695				17. INFORMANT ZIP 21658 ADDRESS Maryland stown Margaret Catherine Smith, Rt31 Box#2 Queen-					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) } DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 11-4 to 11-7 , that (I) (we) last saw the deceased alive on 11-4 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Ralph Libby</i>		22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11-8-82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ralph Libby, M.D.		22e. ADDRESS Grasonville Medical Center, Grasonville Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-10-82		23c. NAME OF CEMETERY OR CREMATORIAL Stevensville Cemetery			23d. LOCATION CITY OR TOWN Stevensville Q.A. Co. Md.				
24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard Funeral Home, Chester, Md.		ADDRESS 21619			25a. DATE REC'D. BY REGISTRAR NOV 15 1982		25b. REGISTRAR'S SIGNATURE <i>John C. Cawie</i>				
DHMH-16 50M 1/81 (VRA 15, 4)											

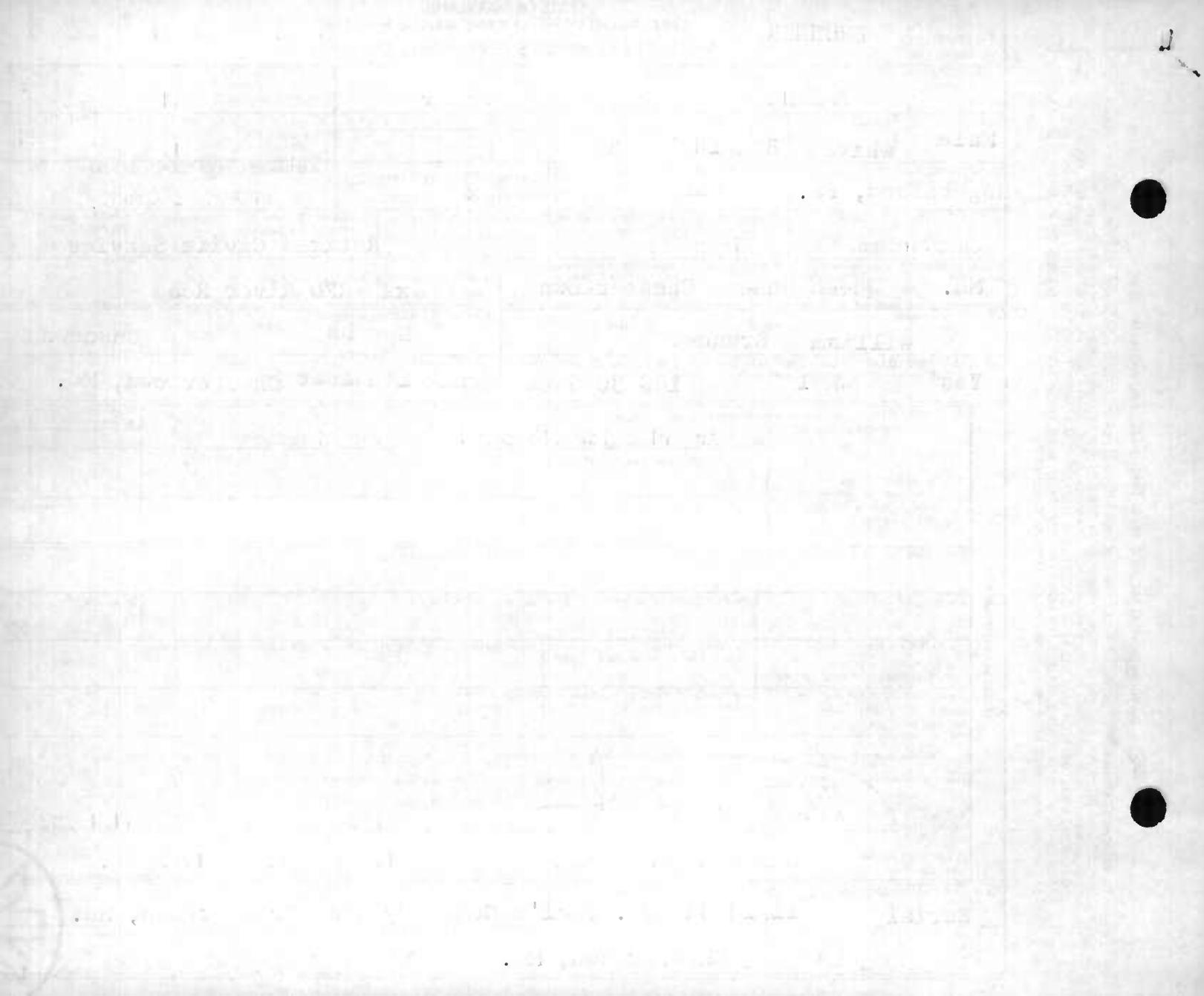
SEARCHED *[Signature]* 1987 31 101

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEFECTS ARE FOUND, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 4 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF CAPITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR		BRUNNER		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		5 2 3 0 1 2 8	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		7a. DATE KNOWN OF DEATH MATED		MONTH DAY YEAR	
Francis		Raymond				Brunner		<input checked="" type="checkbox"/>	<input type="checkbox"/>		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		white		8/2/1897		85 yrs.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		2d. HOUR M.	
Rogersford, Pa.		USA						Queen Anne's County,		6:15 p.m.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE		12b. KIND OF BUSINESS OR INDUSTRY					
Chestertown		River Rd.		Retired Civil Service							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Md.		13b. COUNTY Queen Anne		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RFD River Road	
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME		LAST					
William Brunner				Bertha		Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO. OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW I		17. INFORMANT		ADDRESS					
		148 30 5584		Frank Lindauer		Chestertown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). 19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____							
22a. I certify that I took charge of the deceased described above, held him/her death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE 								Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER								DATE SIGNED 11/10/82			
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.		ADDRESS		111 Penn St. Balto., MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE			
Burial		11/12/82		St. Paul's Cemetery near Chestertown, Md.		Chestertown		County State			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
J.W. Wells		Chestertown, Md.		NOV 15 1982		John J. Conroy					

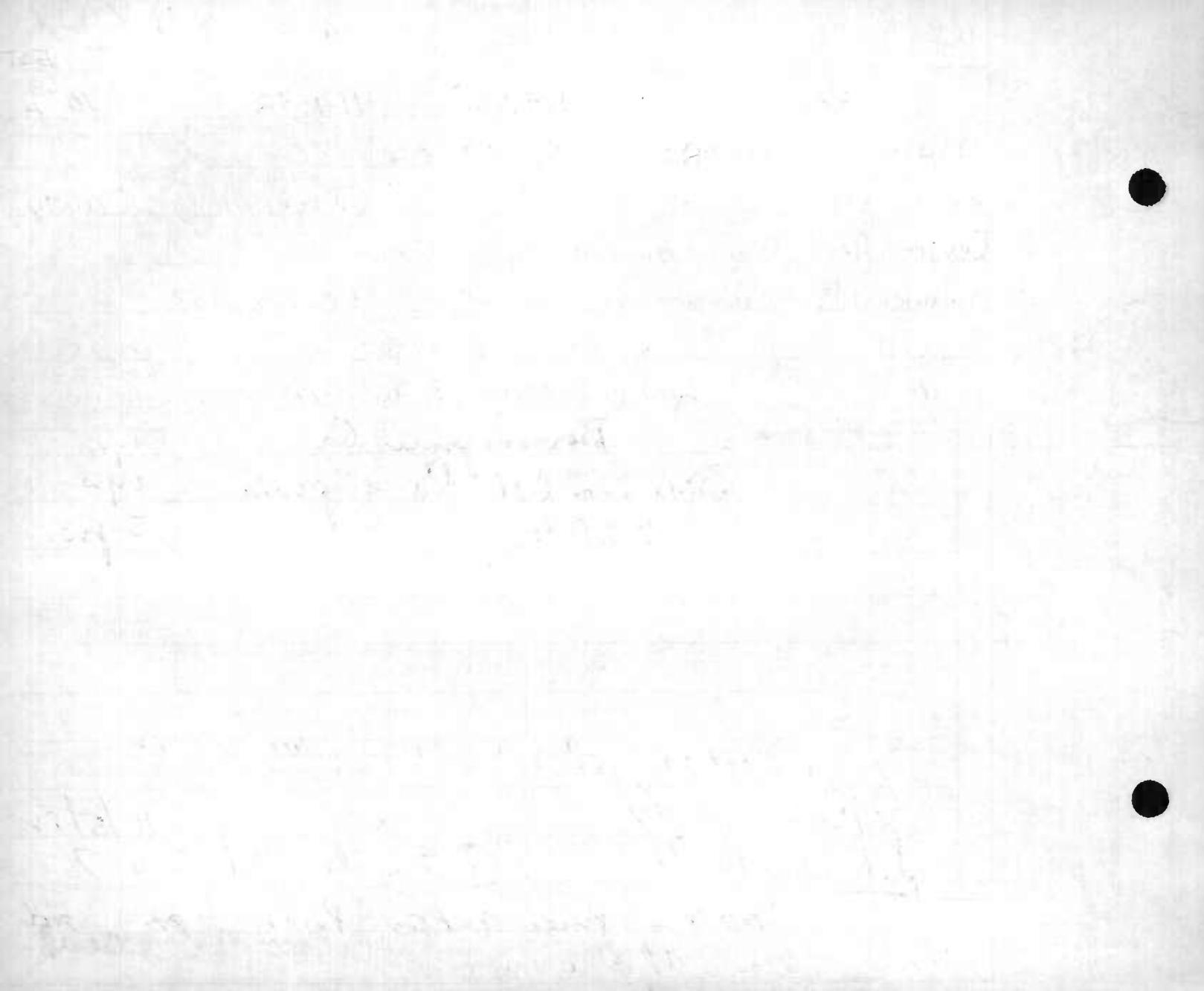


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE												8 2 3 0 1 2 9								
CERTIFICATE OF DEATH												REG. NO.								
1. FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
(TYPE OR PRINT)			Roy						DAVIS			11-1-82						10 ⁴⁰ AM EST		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7a. DATE OF DEATH			IF UNDER 1 YEAR			IF UNDER 24 HRS		
Male			Negro			MONTH DAY YEAR			80			11-1-82			MONTHS DAYS			HOURS MIN		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Keller, VA.			USA									Queen Anne's County								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Centreville			Meridian Nursing Center/Corsica Hills																	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			P.O. Box 288					
MD			Queen Anne's			Grasonville														
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			ADDRESS			P.O. Box 288		
Will									Davis			Bridget						Davis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO			224-14-8788			MARY F. Anderson			Bronchogenic Ca						1 yr.					
1629									DUE TO, OR AS A CONSEQUENCE OF Squamous Cell Ca of penis						2 yrs					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									DUE TO, OR AS A CONSEQUENCE OF COPD						5 yrs					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																				
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		
																		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 9</u> , 19 <u>82</u> , to <u>Nov 1</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Oct 29</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																				
22b. SIGNATURE															DEGREE			22c. DATE SIGNED		
J.R. Smith, Jr.																		11/15/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			23a. BURIAL / CREMATION, REMOVAL (SPECIFY)			23b. DATE 10/1/82			23c. NAME OF CEMETERY OR CREMATORIAL FACILITY			23d. LOCATION CITY OR TOWN		
J.R. Smith, Jr.			Centreville Md 21617																	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			NOV 15 1982			John J. Connelly					
George H. Deschillie Esq. Esq. MD																				

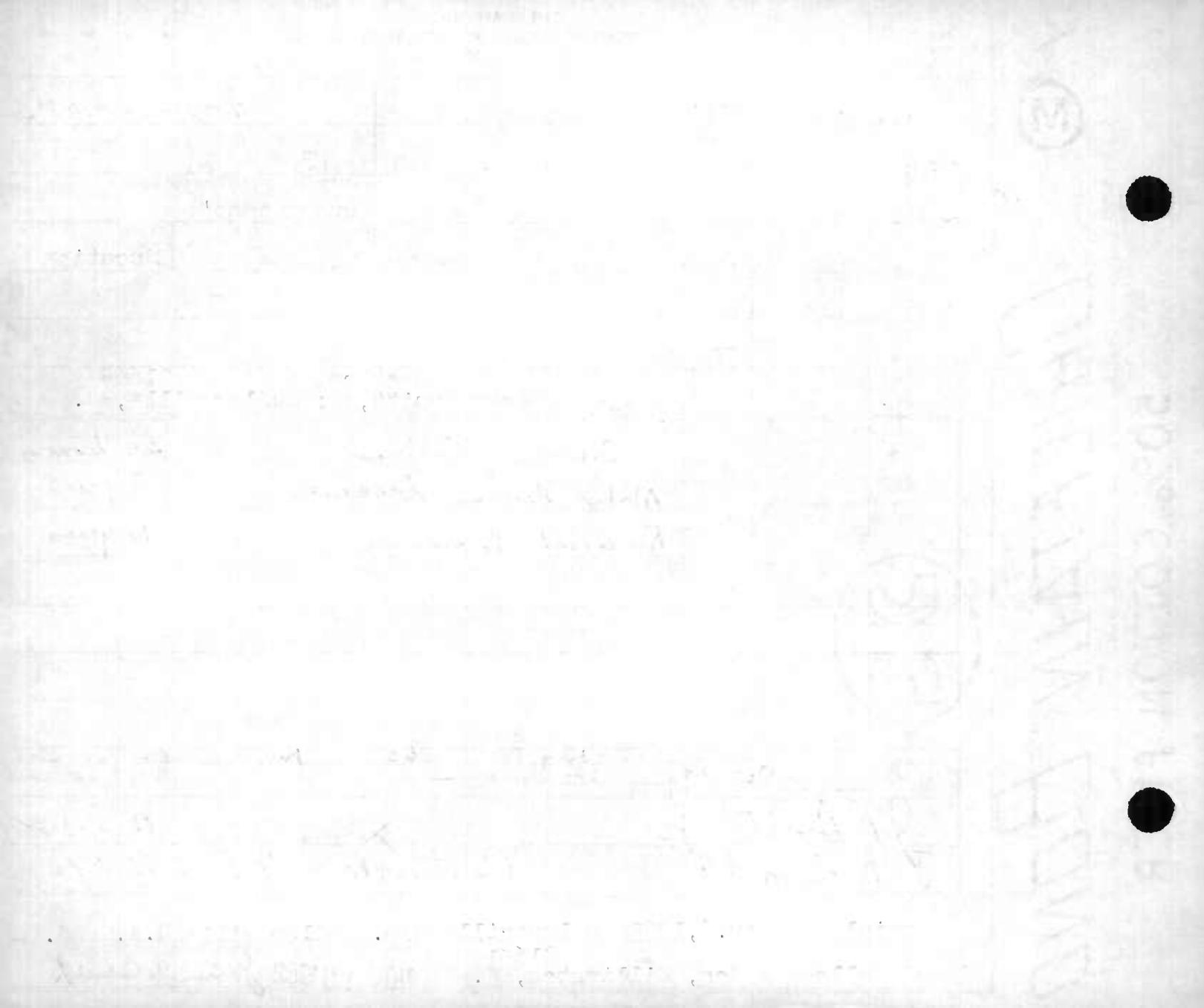


TO HOSPITAL OR ATTENDING PHYSICIAN - The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR - After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 30130 CERTIFICATE OF DEATH												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Bertha Truitt				Higman		11-3-82					10:08 AM				
3. SEX			4. RACE Caucasian			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Male			W			MONTH	DAY	YEAR	75			MONTHS DAYS			
						1	3	1907				HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Sudlersville, Md.			U.S.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Queen Anne's						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Centreville			Menokin Nursing Center-Corsica Hills			Teacher			Education						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
Md.			Queen Anne			Sudlersville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			PO Box 57			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
Spencer					Truitt	Lena				Clayton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No			217-36-2037			Brother			21668			24 hours			
						John Truitt, Sr.; Sudlersville, Md.						3 years			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4100</u> <u>Coronary Occlusion</u> <u>24 hours</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost															
DUE TO OR AS A CONSEQUENCE OF (b) <u>Motor Neuron Disease</u> <u>3 years</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Recurrent Depression</u> <u>10 years</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> , 19 <u>65</u> , to <u>Nov. 1982</u> , that (I) <u>not</u> last saw the deceased alive on <u>Oct. 28</u> , 19 <u>82</u> , and that in (my) <u>not</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>not</u> (will) <u>not</u> view the body after death.															
22b. SIGNATURE			DEGREE						ATTENDING PHYSICIAN			MEDICAL DIRECTOR		STAFF PHYSICIAN	22c. DATE SIGNED
<u>J.R. Smith, Jr.</u>									<input checked="" type="checkbox"/>			<input type="checkbox"/>		<input type="checkbox"/>	<u>11-5-82</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						Centreville			Md 21617			
Burial			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE	
Burial			Nov. 6, 1982			Sudlersville Cem.			Sudlersville			Q.A.		Md.	
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR			REGISTRAR'S SIGNATURE			
Edward Fellows & Son, Millington, Md.			21651						NOV 15 1982			<u>John J. Conigli</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it may be used as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										82 30131				
										REG. NO.				
1 - STATE REGISTRAR			I DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
			Levi					Hollister		October 8, 1982			9:45 AM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		# UNDER 24 HRS			
Male		Caucasian		Nov. 29, 1887			95 YRS		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		MD.					
New York		U. S. A.					Queen Annes							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Queen Anne		First Street			Farmer			Farming						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS						
Maryland		Queen Annes		Queen Annes				First Street						
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
George			Hollister			Emma						Wallace		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No			220263357A			Mrs. Helen Hollister, Queen Anne, Md.							acute	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a)										Myocardial Infarction				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) Arteriosclerotic cardiovascular disease, chronic				
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Previous stroke, recurrent Pneumonia														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/15/82 to 10/8/82, that (I) (we) last saw the deceased alive on 7/16/1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) view the body after death.														
22b. SIGNATURE Christian E. Jensen, M.D.						DEGREE			22c. DATE SIGNED 10/11/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
Christian E. Jensen, M.D.			Kerr Avenue, Denton, Md. 21629											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE
Burial			10/11/82			Denton Cemetery			Denton, Caroline, Md.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
John J. Conner			126 2nd St. Denton, Md.			DEC 2 1982			John J. Conner					

st. 120 northward laboratory
second series structure, internal economy

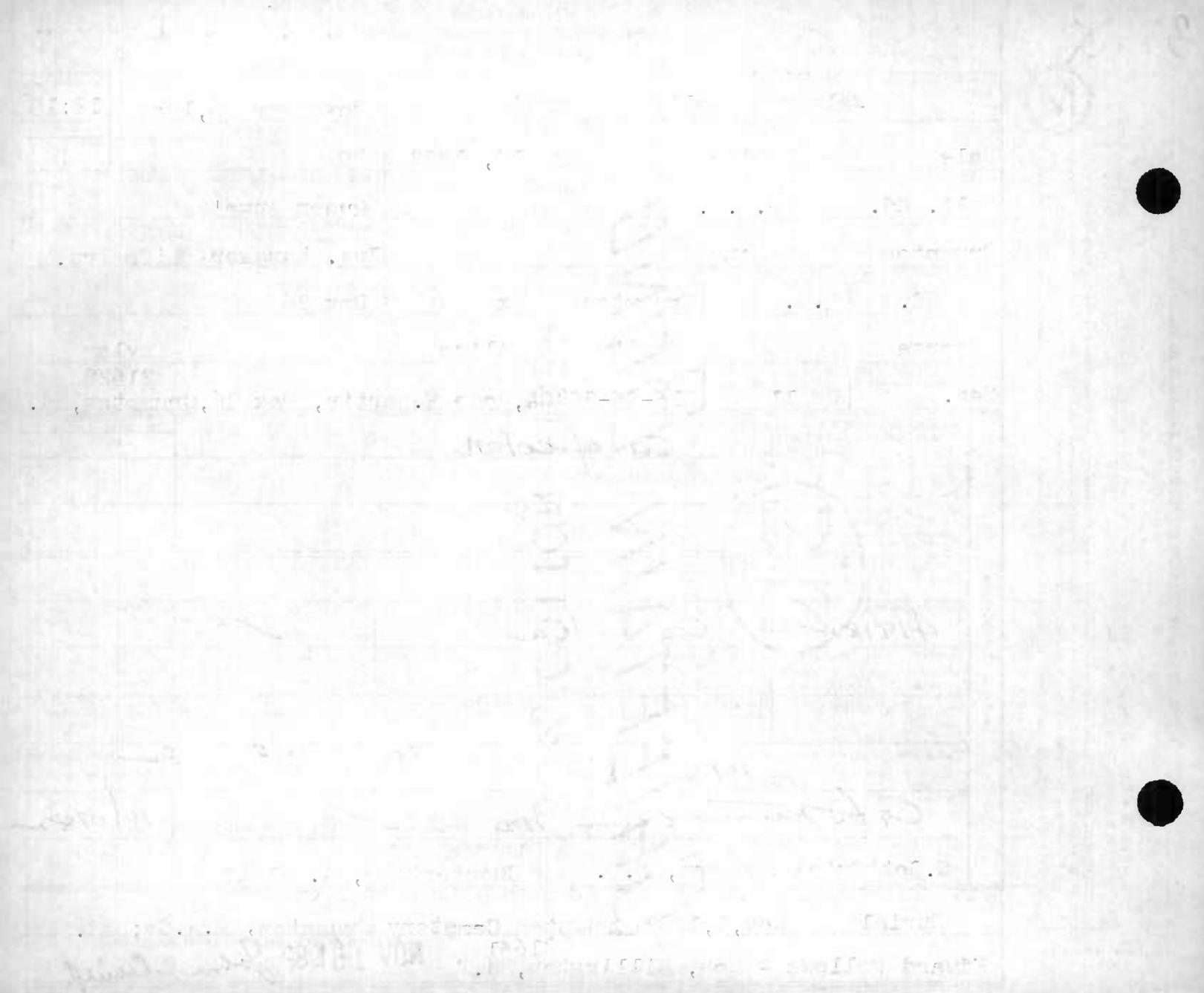
planned tomorrow about 10:00 A.M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										82	30	1	32							
										REG. NO.										
1. FOR STATE REGISTRAR			2a. DATE OF DEATH							MONTH	DAY	YEAR	2b. HOUR							
(TYPE OR PRINT)			Walter			Belt		Martin		November		6, 1982		12:10 ^P						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS					
Male			White			MONTH DAY YEAR			80			MONTHS DAYS			HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH											
Balt. Md.			U.S.A.			May 10, 1902			Queen Anne's			MD.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Crumpton			Home			Ins. Manager			Life Ins.											
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Md.			Q.A.			Crumpton			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Box 26								
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT								
George			Martin			Alice			215-05-3040			A, Rose E. Martin, Box 26, Crumpton, Md.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS											
Yes.			WW 11									21628								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
IMMEDIATE CAUSE (a) <u>Ca of colon</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																				
DUE TO, OR AS A CONSEQUENCE OF (b)																				
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
4/19/82			Ca colon			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)														
			HOUR A.M. MONTH DAY YEAR P.M. 19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE			22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED											
<u>Gottfried Baumann</u>			MD						11/15/82											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Chestertown, Md. 21620														
C. Gottfried Baumann, M.D.																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION			CITY OR TOWN		COUNTY		STATE				
Burial			Nov, 9, 1982			Crumpton Cemetery			Crumpton, Q.A. Co., Md.											
24. FUNERAL DIRECTOR			NAME			ADDRESS			25. DATE REC'D. BY REGISTRAR			REGISTRAR'S SIGNATURE								
			Edward Fellows & Son, Millington, Md.			21651			NOV 15 1982			<u>John J. Canfield</u>								
BP																				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	2	30	1	33								
										REG. NO.												
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST Mina			MIDDLE Virginia			LAST MEREDITH			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR 12:40 P.M.				
3 SEX Female			4. RACE White			5 DATE OF BIRTH MONTH February			DAY 15			YEAR 1891			6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/>			DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's			MD.				
10 CITY OR TOWN OF DEATH Centreville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Center/ Corsica Hills			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wife			12b KIND OF BUSINESS OR INDUSTRY Home													
13a STATE Centreville			13b COUNTY Queen Anne's			13c CITY OR TOWN Centreville			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 311 Chesterfield Ave.										
14 FATHER'S NAME FIRST William			MIDDLE Edward			LAST Simpson			15 MOTHER'S MAIDEN NAME FIRST Sarah			MIDDLE Elizabeth			LAST Jewell							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 214-28-3533			17 INFORMANT Husband John T. Meredith, Centreville, Md. 21617			ADDRESS 311 Chesterfield Ave.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years										
18 CAUSE OF DEATH (Enter only one cause per line for 1(a), 1(b) and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140										ASHD H.C.V.W.												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b).										DUE TO, OR AS A CONSEQUENCE OF (c)												
DUE TO, OR AS A CONSEQUENCE OF (b).										DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																						
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE							
22a. I certify that (I) (this hospital) attended the deceased from July 1, 1962 to Nov 12, 1982 , that (I) (we) last saw the deceased alive on Nov 12, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																						
22b. SIGNATURE <i>J.R. Smith, Jr.</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11/13/1982													
22e. ADDRESS Centreville, Md. 21617																						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 15, 1982			23c. NAME OF CEMETERY OR CREMATORIAL Chesterfield			23d. LOCATION CITY OR TOWN Centreville, Q.A. Co., Md.			COUNTY			STATE							
24 FUNERAL DIRECTOR NAME James H. Barton, Jr., Centreville, Md. 21617			ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 16 1982			25b. REGISTRAR'S SIGNATURE <i>John J. Cahill</i>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

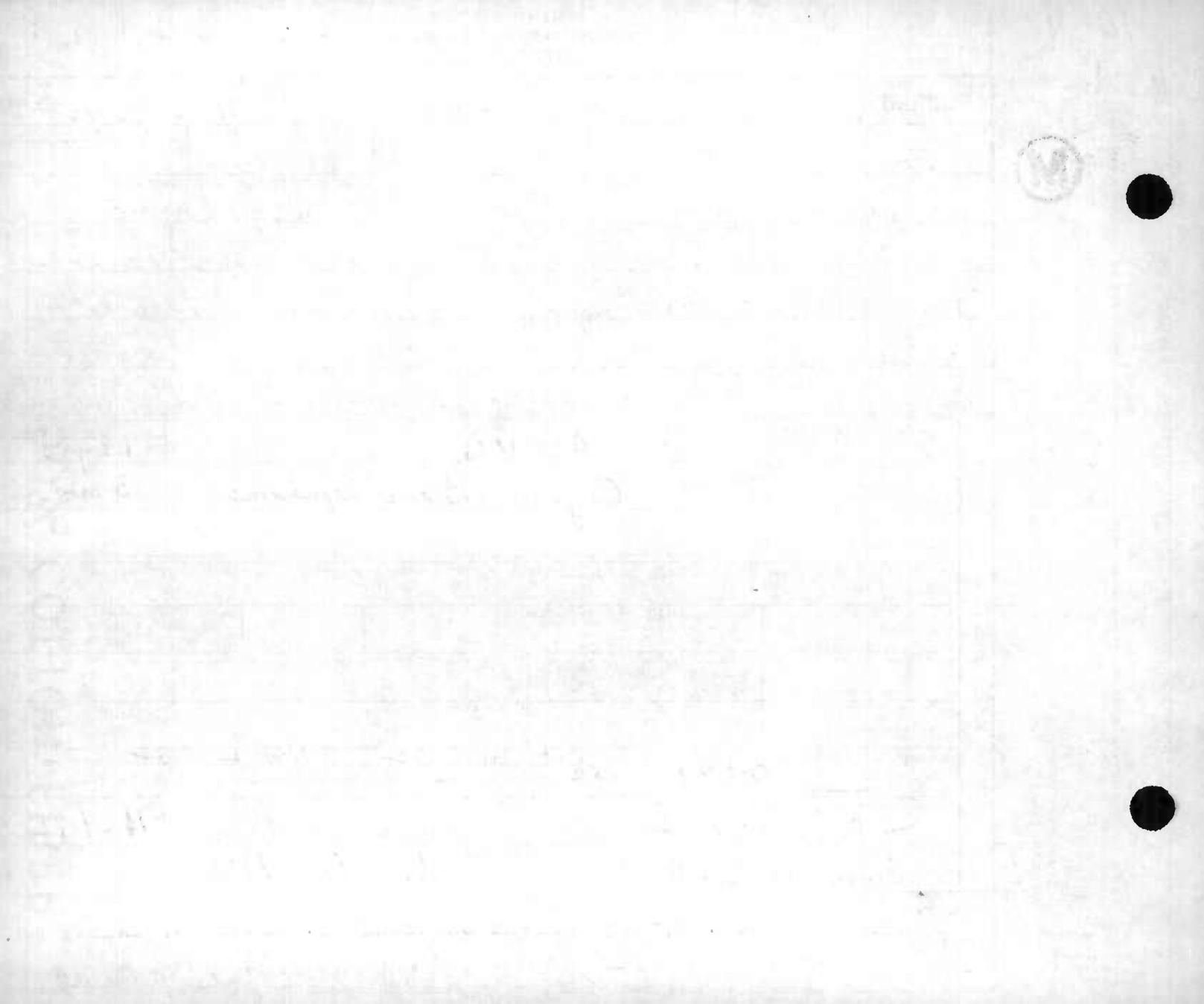
MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 0 1 3 4

REG. NO.

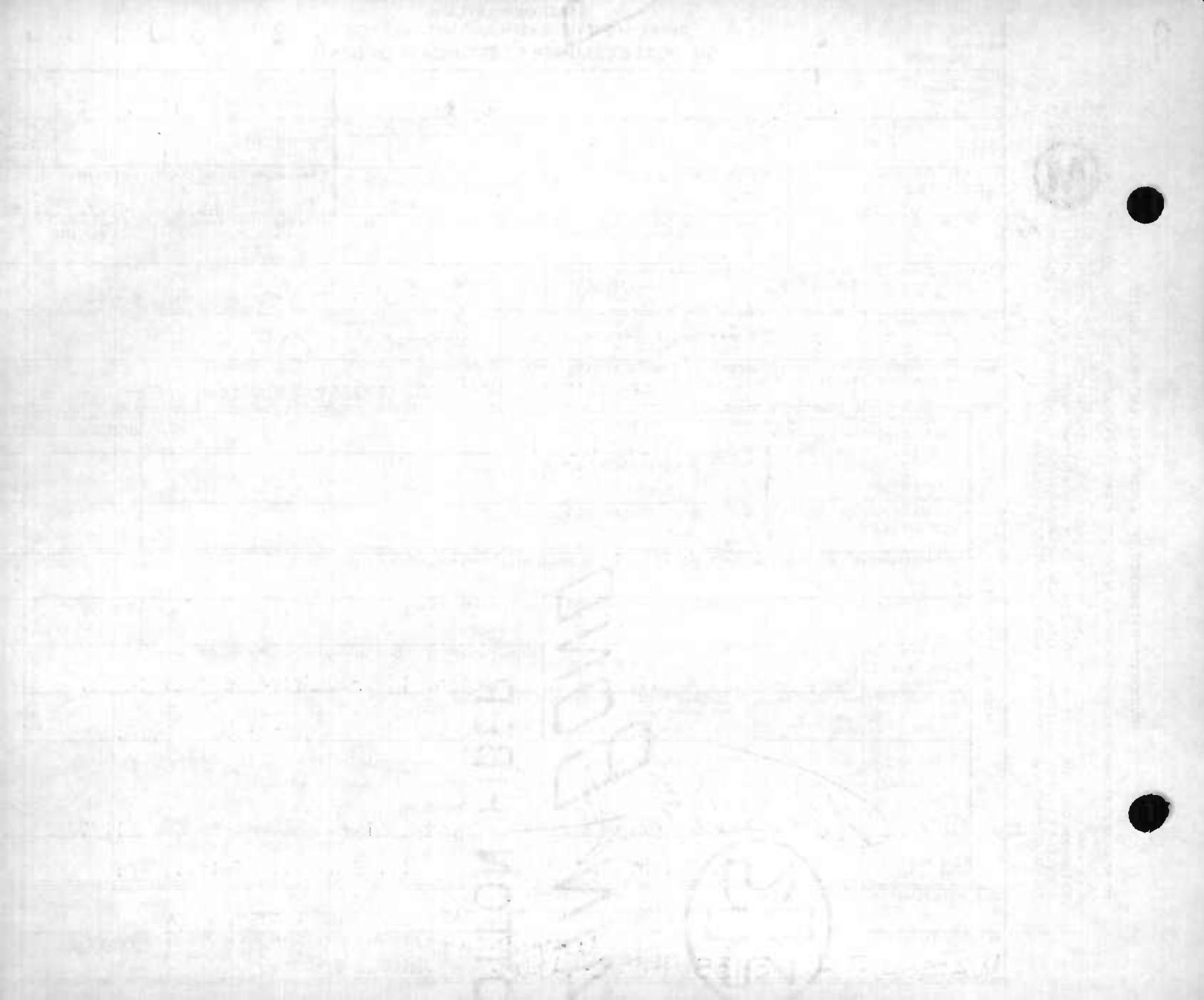
1. DECEASED NAME (TYPE OR PRINT) SARAH VIRGINIA SHARP SHINN			2a. DATE OF DEATH 11-2-82	MONTH YEAR	DAY	2b. HOUR 12:25 P.M.					
3. SEX Female	4. RACE II B	5. DATE OF BIRTH MONTH DAY YEAR 8-8-02	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH QUEEN ANNE			MD.					
10. CITY OR TOWN OF DEATH Centreville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERIDIAN Corsica Hills Nursing Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School teacher					
13a. STATE MD.			13b. COUNTY TALBOT			13c. CITY OR TOWN St. Michaels			12b. KIND OF BUSINESS OR INDUSTRY Education		
14. FATHER'S NAME FIRST GEORGE			LAST SHARP			15. MOTHER'S MAIDEN NAME FIRST NETTIE			LAST KEPLER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) UNKNOWN			16b. SOCIAL SECURITY NO. 219-36-7344			17. INFORMANT PATRICIA S. BOHA			ADDRESS RIVERVIEW TERRACE ST. MICHAELS, MD. 21663		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY 4292			IMMEDIATE CAUSE (a) ASC-V2			DUE TO, OR AS A CONSEQUENCE OF (b) Organic Brain Syndrome			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs		
									3 mos.		
19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from Oct 29 1982 to Nov 2 1982 , that (I) (we) lost saw the deceased alive on Oct 29 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE JR Smith Jr.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-4-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Smith, Jr.			22e. ADDRESS Centreville Md								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE NOV. 5, 1982			23c. NAME OF CEMETERY OR CREMATORIAL OLIVET CEMETERY			23d. LOCATION CITY OR TOWN ST. MICHAELS, TALBOT MD.		
24. FUNERAL DIRECTOR NAME Harrison E. Lowney St. Michaels, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 12 1982			25b. REGISTRAR'S SIGNATURE James J. Curran		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 30135											
1- STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2b. HOUR						
1. DECEASED NAME (TYPE OR PRINT)			Gregory			Vaughan			<input checked="" type="checkbox"/>			11	7	1982	M								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
MALE		BLK		JUNE 29 1956			26 yrs.							11 7 1982		8:30		a.m.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH														
GERMANY			USA			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Queen Anne's County,														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY														
Queenstown			Rt. 50			TECHNICIAN																	
13a. STATE MD.			13c. CITY OR TOWN HYATTS,			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1902 AMHEARST RD. #203														
14. FATHER'S NAME GEORG			MIDDLE V. LAST VAUGHAN JR.			15. MOTHER'S MAIDEN NAME VIRGINIA L. HEATH																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. NOT STATED			17. INFORMANT CAROLYN BELLAMY 8600 16th ST. SIL. SP. MD.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8158												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
(b) DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?																	
									<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR XX MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
7:15 P.M. 11 7 1982						Occupant in truck/fixed object impact																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.) street			21f. LOCATION STREET Rt. 50			CITY OR TOWN Queenstown			COUNTY Q.A.		STATE MD.									
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																				
ACTUAL SIGNATURE <i>Thomas D. Smith</i>									TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER														
EXAMINER'S NAME (TYPE OR PRINT)			Thomas D. Smith, M.D.			ADDRESS 111 Penn ST. Balt., MD.			DATE SIGNED 11/7/82														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN PETERSBURG,			COUNTY VA.			STATE											
BURIAL			NOV 11 1982 DINWIDDIE MEM. PARK																				
24. FUNERAL DIRECTOR NAME			ADDRESS WATSON F.H. 3435 14th St. N.W.			25a. DATE REC'D. BY REGISTRAR 756 REGISTRAR'S SIGNATURE NOV 18 1982 <i>John J. Smith</i>																	
BP																							
DHMH - 17 (VR AT 5 ME (5))																							
20M 4/82																							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 0 1 3 6			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Pearl Virginia WOODROW						November 30, 1982						3:52 P.M.	
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female			White		September 5, 1901		81			MONTHS	YEARS	HOURS	MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland			USA				Queen Anne's						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Centreville			Meridian Nursing Center/Corsica Hills			Wife			Home				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Maryland			QueenAnne's		Centreville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Kidwell Ave. 21617			
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
Pratt			-----	Taylor	Ida			-----	Tribbitt				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS					
No			218-20-8325		Daughter			202 Wrightson Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY:			18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
IMMEDIATE CAUSE (a) 4140			10 years										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 30</u> , 1982, to <u>Nov. 30</u> , 1982, that (I) (we) last saw the deceased alive on <u>Nov. 30</u> , 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>J.R. Smith Jr.</i>													
22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>12-2-82</u>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			John R. Smith, Jr., M.D.			22f. ADDRESS			Centreville, Md. 21617				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			23d. LOCATION CITY OR TOWN			COUNTY STATE		
Burial			Dec. 3, 1982		Chesterfield			Centreville, Q.A.Co., Md.					
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Barton Bros.													
James H. Barton, Jr., Centreville, Md. 21617			DEC 14 1982			<i>John R. Smith Jr.</i>							

Scallop shell of red sandstone

to 1911, naturalized 1912, - since
September 1912, naturalized 1912, - since
September 1912, naturalized 1912, - since

September 1912, naturalized 1912, - since

1912, naturalized 1912, - since

September 1912, naturalized 1912, - since

September 1912, naturalized 1912, - since

1912, naturalized 1912, - since